| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *UHLC-126409713* | *State:* | *Arkansas* |
| *Filing Company:* | *UnitedHealthcare Insurance Company* | *State Tracking Number:* | *44273* |
| *Company Tracking Number:* | *S93136AGMMAR01 01B* | | |
| *TOI:* | *MS07G Group Medicare Supplement - Medicare Select 2010* | *Sub-TOI:* | *MS07G.003 Plan C 2010* |
| *Product Name:* | *MEDICARE SELECT* | | |
| *Project Name/Number:* | *MIPPA 360 APP/S93136AGMMAR01 01B* | | |

## Filing at a Glance

Company: UnitedHealthcare Insurance Company

| | | |
|---|---|---|
| Product Name: MEDICARE SELECT | SERFF Tr Num: UHLC-126409713 | State: Arkansas |
| TOI: MS07G Group Medicare Supplement - Medicare Select 2010 | SERFF Status: Closed-Approved-Closed | State Tr Num: 44273 |
| Sub-TOI: MS07G.003 Plan C 2010 | Co Tr Num: S93136AGMMAR01 01B | State Status: Filed-Closed |
| Filing Type: Form | | Reviewer(s): Stephanie Fowler |
| | Author: Bobbie Walton | Disposition Date: 01/06/2010 |
| | Date Submitted: 12/08/2009 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: MIPPA 360 APP | Status of Filing in Domicile: Not Filed |
| Project Number: S93136AGMMAR01 01B | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Group |
| Submission Type: New Submission | Group Market Size: Large |
| Overall Rate Impact: | Group Market Type: Association |
| Filing Status Changed: 01/06/2010 | Explanation for Other Group Market Type: |
| | State Status Changed: 01/06/2010 |
| Deemer Date: | Created By: Bobbie Walton |
| Submitted By: Bobbie Walton | Corresponding Filing Tracking Number: |

Filing Description:

RE: United HealthCare Insurance Company
AARP Medicare Supplement Enrollment Application
MIPPA 360 Enrollment Application
NAIC No: 0707-79413
File No: S93136AGMMAR01 01B (PLEASE USE THIS NUMBER IN ALL CORRESPONDENCE)

We enclose for your information and review, proof copies of enrollment application for use in connection with AARP

group health insurance program. The enclosed enrollment application is new and does not replace any material previously submitted to the Department.

Standardized Medicare Select Certificate: MDSC 0008, MDSF 0009 (Mass Media Marketing) - Approved by the Department on 11/5/09, State Tracking Number 43459.

The definitions, disclosures, eligibility requirements, exclusions, limitations, Group Policy Form No. GRP 79171 GPS-1, as well as, the statement, "…not connected with, or endorsed by, the U.S. Government or the federal Medicare program," can be found in GU25003AR which was approved by the Department on 11/3/09 under State Tracking Number 43646.

We trust the enclosed forms are in order and look forward to your prompt acknowledgment of this filing. If you have any further questions you can contact me at (215-902-8444). If you prefer, you may also send a facsimile to me at Fax: 215-902-8813 or send an email to me at Susan_J_Cipollo@uhc.com.

## Company and Contact

**Filing Contact Information**

Susan Cipollo, Director
680 Blair Mill Rd.
Horsham, PA 19044

Susan_J_Cipollo@uhc.com
215-902-8444 [Phone]
215-902-8813 [FAX]

**Filing Company Information**

UnitedHealthcare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(860) 702-5000 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number:

---

## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $20.00 |
| Retaliatory? | No |
| Fee Explanation: | $20 PER FORM - 1 ENROLLMENT FORM = $20 |
| Per Company: | No |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *UHLC-126409713* | *State:* | *Arkansas* |
| *Filing Company:* | *UnitedHealthcare Insurance Company* | *State Tracking Number:* | *44273* |
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| *Product Name:* | *MEDICARE SELECT* | | |
| *Project Name/Number:* | *MIPPA 360 APP/S93136AGMMAR01 01B* | | |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| UnitedHealthcare Insurance Company | $20.00 | 12/08/2009 | 32568596 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *UHLC-126409713* | *State:* | *Arkansas* |
| *Filing Company:* | *UnitedHealthcare Insurance Company* | *State Tracking Number:* | *44273* |
| *Company Tracking Number:* | *S93136AGMMAR01 01B* | | |
| *TOI:* | *MS07G Group Medicare Supplement - Medicare Select 2010* | *Sub-TOI:* | *MS07G.003 Plan C 2010* |
| *Product Name:* | *MEDICARE SELECT* | | |
| *Project Name/Number:* | *MIPPA 360 APP/S93136AGMMAR01 01B* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Stephanie Fowler | 01/06/2010 | 01/06/2010 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *UHLC-126409713* | *State:* | *Arkansas* |
| *Filing Company:* | *UnitedHealthcare Insurance Company* | *State Tracking Number:* | *44273* |
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| *Product Name:* | *MEDICARE SELECT* | | |
| *Project Name/Number:* | *MIPPA 360 APP/S93136AGMMAR01 01B* | | |

# Disposition

Disposition Date: 01/06/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *UHLC-126409713* | *State:* | *Arkansas* |
| *Filing Company:* | *UnitedHealthcare Insurance Company* | *State Tracking Number:* | *44273* |
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| *Product Name:* | *MEDICARE SELECT* | | |
| *Project Name/Number:* | *MIPPA 360 APP/S93136AGMMAR01 01B* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Accepted for Informational Purposes | Yes |
| **Supporting Document** | Application | | Yes |
| **Supporting Document** | Health - Actuarial Justification | | Yes |
| **Supporting Document** | Outline of Coverage | | Yes |
| **Form** | 360 APP | Approved | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *UHLC-126409713* | *State:* | *Arkansas* |
| *Filing Company:* | *UnitedHealthcare Insurance Company* | *State Tracking Number:* | *44273* |
| *Company Tracking Number:* | *S93136AGMMAR01 01B* | | |
| *TOI:* | *MS07G Group Medicare Supplement - Medicare Select 2010* | *Sub-TOI:* | *MS07G.003 Plan C 2010* |
| *Product Name:* | *MEDICARE SELECT* | | |
| *Project Name/Number:* | *MIPPA 360 APP/S93136AGMMAR01 01B* | | |

# Form Schedule

**Lead Form Number: S93136AGMMAR01 01B**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved 01/06/2010 | S93136AGMMAR01 01B | Application/ Enrollment Form | 360 APP | Initial | | 50.000 | S93136AGMMAR01 01B.pdf |

# Application Form

## AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

AARP Membership Number (If you are already a member)

_____ – _____

First Name MI Last Name

Address Line 1

Address Line 2

City ST Zip

**Note:** Plans and rates described in this package are good only for residents of xxxxxxxxxxx.

### Instructions

1. Fill in all requested information on this form and be sure to sign where indicated.
2. Print clearly. Use CAPITAL letters.
3. Fill in the circles with black or blue ink. Not pencil.

*Example:* ○ Y ● N

☞ If you are not already an AARP Member, please include your AARP Membership Application and a check or money order for your annual Membership dues with this application.

✉ If reply envelope is missing, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.

## 1 Tell us about yourself

**Birthdate**

M M D D Y Y Y Y

**Gender**

○ M ○ F

**Phone**

Area Code and Phone Number

**Please supply the following information, found on your Medicare card.**

MEDICARE HEALTH INSURANCE

NAME
First / Middle Initial / Last

MEDICARE CLAIM #

HOSPITAL (PART A) EFFECTIVE DATE: M M 0 1 Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE: M M 0 1 Y Y Y Y

ARE BOTH MEDICARE PARTS A & B COVERAGE ACTIVE? ○ Y ○ N

**E-mail address (optional)**

By providing your email address, you are agreeing to receive important account information and product offers.
Be sure to write all necessary periods (.) and symbols (@) in their space.

Barcode
1.75" x .75"

XXXXXXXXXX

Continued on next page ▶

## 2 Choose your plan and effective date

**Please indicate your plan choice below:**

○ A ○ B ○ C [○ D] ○ F [○ G] ○ K ○ L [○ M] ○ N

Select Plan C ○

Select Plan F ○

**You are eligible to enroll if <u>all</u> of these are true:**

- you are an AARP member,
- you are age 65 or older,
- you are enrolled in Medicare Parts A&B,
- you are not duplicating Medicare supplement coverage.

**Coverage Effective Date**

Your coverage will become effective on the first day of the month following receipt and approval of this application and first month's premium. You will receive a Certificate of Insurance confirming your effective date.

If you would like your coverage to begin on a later date (the 1st day of a future month), please indicate below.

Requested Effective Date

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| M | M | 0 D | 1 D | Y | Y | Y | Y |

## 3 Answer these questions to determine if your acceptance is guaranteed

**3A.** Did you turn age 65 in the last 6 months?

○ Y ○ N **If YES,** skip to **Section 7.**

**3B.** Did you enroll in Medicare Part B within the last 6 months?

○ Y ○ N **If YES,** skip to **Section 7.**

**3C.** Will your plan effective date be within 6 months after turning age 65 and enrolling in Medicare Part B?

○ Y ○ N **If YES,** skip to **Section 7.**

- If you answered **YES to 3A, 3B, or 3C,** your acceptance is guaranteed.
- If you answered **NO to 3A, 3B, and 3C,** continue to question **3D**. ⇗

**3D.** Have you lost other health insurance coverage and, if so, are you an "eligible person" as defined within the termination notice you received from your prior insurer?

○ Y ○ N

**If YES,** skip to **Section 7.**

- If you answered **YES to 3D,** you may be guaranteed acceptance in certain AARP Medicare Supplement Plans. **Include a copy of the termination notice with your application.**
- If you answered **NO** to all questions in this section **(3A, 3B, 3C and 3D),** go to **Section 4.** ⇩

## 4 Tell us about your tobacco usage

If you have smoked cigarettes or used any tobacco product at any time within the past twelve months, darken this circle: ○

Continued on next page ▶

## 5 Answer these health questions to determine if you are eligible for this coverage

**5A.** Do any of these apply to you?

- have end stage renal (kidney) disease
- currently receiving dialysis
- diagnosed with kidney disease that may require dialysis
- admitted to a hospital as an inpatient within the past 90 days

◯ Y ◯ N

**5B.** Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has **NOT** been completed:

- hospital admittance as an inpatient
- organ transplant
- back or spine surgery
- joint replacement
- surgery for cancer
- heart surgery
- vascular surgery

◯ Y ◯ N

STOP **If you answered YES to either question in this section, you are NOT eligible for these plans at this time.**

If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

**If you answered NO to <u>both</u> questions in this section, please continue to Section 6.**

## 6 Tell us if you have any of these medical conditions to determine your rate

**Complete this section <u>only</u> if you enrolled in Medicare Part B <u>7 or more months ago</u>.** All others go to Section 7.

Read the conditions listed below carefully. If <u>within the past two years</u>, you have been diagnosed, treated, or had any of the following conditions, darken the circle next to it. If you are unsure how to respond, please consult your physician.

### 6A. Heart or Vascular Conditions

◯ Aneurysm
◯ Arteriosclerosis or Atherosclerosis
◯ Artery or Vein Blockage
◯ Atrial Fibrillation or Atrial Flutter
◯ Cardiomyopathy
◯ Carotid Artery Disease
◯ Congestive Heart Failure (CHF)
◯ Coronary Artery Disease (CAD)
◯ Heart Attack
◯ Peripheral Vascular Disease or Claudication
◯ Stroke, Transient Ischemic Attack (TIA), or mini-stroke
◯ Ventricular Tachycardia

### 6B. Diabetes

◯ With any of the following complications: Circulatory problems, Kidney problems, or Retinopathy

### 6C. Lung/Respiratory Conditions

◯ Chronic Obstructive Pulmonary Disease (COPD)
◯ Emphysema

### 6D. Cancer or Tumors

◯ Cancer (other than skin cancer)
◯ Leukemia or Lymphoma
◯ Melanoma

Continued on next page ▶

## 6 Tell us if you have any of these medical conditions to determine your rate – continued

**Complete this section only if you enrolled in Medicare Part B 7 or more months ago.** All others go to Section 7.

Read the conditions listed below carefully. If within the past two years, you have been diagnosed, treated, or had any of the following conditions, darken the circle next to it. If you are unsure how to respond, please consult your physician.

**6E. Kidney Conditions**
- ○ Chronic Renal Failure or Insufficiency
- ○ Polycystic Kidney Disease
- ○ Renal Artery Stenosis

**6F. Liver**
- ○ Cirrhosis of the Liver

**6G. Transplants**
- ○ Bone marrow or organ transplant

**6H. Gastrointestinal Conditions**
- ○ Chronic Pancreatitis
- ○ Esophageal Varices

**6I. Musculoskeletal Conditions**
- ○ Amputation due to disease
- ○ Rheumatoid Arthritis
- ○ Spinal Stenosis

**6J. Substance Abuse**
- ○ Alcohol Abuse or Alcoholism
- ○ Drug Abuse or use of illegal drugs

**6K. Brain or Spinal Cord Conditions**
- ○ Paraplegia, Quadriplegia or Hemiplegia

**6L. Psychological/Mental Conditions**
- ○ Bipolar or Manic Depressive
- ○ Schizophrenia

**6M. Eye Condition**
- ○ Macular Degeneration

**6N. Nervous System Conditions**
- ○ Amyotrophic Lateral Sclerosis (ALS)
- ○ Alzheimer's Disease or Dementia
- ○ Multiple Sclerosis (MS)
- ○ Parkinson's Disease
- ○ Systemic Lupus Erythematosus (SLE)

**6O. Immune System Conditions**
- ○ AIDS
- ○ HIV positive

**If you darkened a circle for any of the medical conditions in this Section (6), your rate will be the level 2 rate. Please see the enclosed "Cover Page – Rates."**

Continued on next page ▶

## 7 Tell us about your past and current coverage

**Please review the statements below, then answer all questions to the best of your knowledge.**

- You do not need more than one Medicare Supplement insurance policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

---

**For your protection, you are required to answer all the questions below (7A through 7L) and sign in the signature box on the next page.**

**7A.** Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.)

**Note to applicant:** If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer **NO** to this question.

◯ Y ◯ N

**If NO,** skip to question **7D.**
**If YES,** please continue to **7B** and **7C.**

**7B.** Will Medicaid pay your premiums for this Medicare supplement policy?

◯ Y ◯ N

**7C.** Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

◯ Y ◯ N

Continued on next page ▶

## 7 Tell us about your past and current coverage – continued

**7D.** Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

○ Y ○ N

**If NO,** skip to question **7H**.
**If YES,** fill in your start and end dates and continue to question **7E**. If you are still covered under this plan, leave the end date blank.

**Start Date** **End Date**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | | | | | | | 0 | 1 | | | | |
| M | M | D | D | Y | Y | Y | Y | M | M | D | D | Y | Y | Y | Y |

**7E.** If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

○ Y ○ N

**7F.** Was this your first time in this type of Medicare plan?

○ Y ○ N

**7G.** Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

○ Y ○ N

---

**7H.** Do you have another Medicare Supplement policy in force?

○ Y ○ N

**If NO,** skip to question **7J**.
**If YES,** please continue.

**7I. If YES,** do you intend to replace your current Medicare Supplement policy with this policy?

○ Y ○ N

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**7J.** Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?

○ Y ○ N

**If NO,** please sign below, then continue to **Section 8.**
**If YES,** please list with what company and what type of policy in the space provided below. Then continue to question **7K**.

**Company Name**

**Policy Type**

○ HMO/PPO ○ Major Medical ○ Employer Plan
○ Union Plan ○ Other_____

**7K.** What are your dates of coverage under the policy you listed in **7J?** Leave the end date blank if you are still covered under the other policy.

**Start Date** **End Date**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| M | M | D | D | Y | Y | Y | Y | M | M | D | D | Y | Y | Y | Y |

**7L.** Are you replacing this health insurance?

○ Y ○ N

**Your Signature – 1** (required)

X _____

Continued on next page ▶

## 8 Authorization and Verification of Information

**Please read carefully, and sign and date in the highlighted area below.**

- My signature indicates I have read and understand the contents of this application form.
- I declare the answers on this application form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this application form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand an agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company, and actual rates are not determined until coverage is issued.
- I understand an agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- If you are enrolling in a Medicare Select Plan: I acknowledge that I have received an Outline of Coverage, Grievance Procedure, Provider Directory and a Medicare Select Disclosure Statement covering Provider Restrictions, Right to Replace Your Medicare Supplement Plan and Quality Assurance Program. I affirm that I understand the benefits, restrictions, limitations and other provisions of the Medicare Select Plan for which I am applying.
- I acknowledge that I have reviewed the Outline of Coverage.
- I understand an agent discussing plan options with me is appointed by UnitedHealthcare Insurance Company, and may be compensated based on my enrollment in a plan.

**Authorization for the Release of Medical Information**
I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage and rate. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. This authorization is valid for 24 months from the date of my signature.

Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you.

**I understand the plan will not pay benefits for stays beginning or medical expenses incurred during the first 3 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 3 months prior to the insurance effective date.**

**I have read all information and have answered all questions to the best of my ability.**

**Your Signature – 2** (required)

X _____

**Today's Date** (required)

M M D D Y Y Y Y

**Note:** If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Continued on next page ▶

## 8 Authorization and Verification of Information

**Please read carefully, and sign and date in the highlighted area below.**

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

**Your Signature – 3**

X _____

**Today's Date**

M M D D Y Y Y Y

**Note:** If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

**Plan Rates**

Please refer to the "Cover Page - Rates" for the monthly cost of the plan you have selected. If you answered YES to any medical conditions in Section 6, your rate will be the level 2 rate.

Once your application is processed, you'll be notified of your acceptance, rate and insurance start date.

Please submit your first month's payment with this application. Make your check or money order payable to: UnitedHealthcare Insurance Company. If you are currently insured under an AARP Medicare Supplement Plan, Send No Money Now. You will receive updated payment instructions later.

## 9 For Agent Use Only

**If application is being made through an Agent,** he or she must complete the following; and if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

1. List any other medical or health insurance policies sold to the applicant:

2. List any policies that are still in force:

3. List policies sold in the past five years that are no longer in force:

Agent Name (PLEASE PRINT) First Name MI Last Name

Agent Phone Number

X _____ Agent Signature (required)

Agent ID (required)

M M D D Y Y Y Y

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *UHLC-126409713* | *State:* | *Arkansas* |
| *Filing Company:* | *UnitedHealthcare Insurance Company* | *State Tracking Number:* | *44273* |
| *Company Tracking Number:* | *S93136AGMMAR01 01B* | | |
| *TOI:* | *MS07G Group Medicare Supplement - Medicare Select 2010* | *Sub-TOI:* | *MS07G.003 Plan C 2010* |
| *Product Name:* | *MEDICARE SELECT* | | |
| *Project Name/Number:* | *MIPPA 360 APP/S93136AGMMAR01 01B* | | |

# Supporting Document Schedules

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Satisfied - Item:** | Flesch Certification | Accepted for Informational Purposes | 01/06/2010 |

**Comments:**

**Attachment:**

READABILITY CERTIFICATION FORM 8 24 09.pdf

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Bypassed - Item:** | Application | | |
| **Bypass Reason:** | ENROLLMENT APPLICATION ATTACHED UNDER FORM SCHEDULE | | |
| **Comments:** | | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Bypassed - Item:** | Health - Actuarial Justification | | |
| **Bypass Reason:** | N/A | | |
| **Comments:** | | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Bypassed - Item:** | Outline of Coverage | | |
| **Bypass Reason:** | N/A | | |
| **Comments:** | | | |

**UnitedHealthcare Insurance Company**
**READABILITY CERTIFICATION**

**THIS IS TO CERTIFY THAT THE FOLLOWING FORM(S) HAS ACHIEVED A FLESCH READING EASE TEST SCORE OF:**

| FORM NUMBER | FLESCH SCORE |
|---|---|
| S93136AGMMAR01 01B | 50 |

**SIGNATURE**

PAUL D. KALLMEYER, **Assistant Secretary, UHIC**
**NAME AND TITLE**

**December 8, 2009**
**DATE**